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PRIMARY HEALTH CARE TOWARDS THE YEAR 2000

A REPORT OF THE CONSULTATIVE COMMITTEE
ON PRIMARY HEALTH CARE DEVELOPMENT

Geneva 9 - 12 April 1990

WORLD HEALTH ORGANIZATION

''The symbol on the cover was used at the Alma Ata Conference on Primary Health Care in 1978 and subsequent Declaration. It represents Primary Health Care as the key to Health for All''.

PRIMA

CONSUI

SUMMARY

This report addresses the future of primary health care in the 1990s, and considers the implications for the role of WHO. Many working successes in primary health care can be found, and many system-wide failures. Greater clarity of purpose and better information on factors contributing to success and failure are needed. The central principle of equity as the locomotive for primary health care needs re-emphasis in the rapidly-changing environment of the 1990s. PHC strategies need to develop pluralistic and flexible responses to achieving equity in shifting socio- political circumstances, and in a wide range of economic and ecological conditions. The report is in six sections. The first selectively reviews what can be learned from the decade of PHC experience since Alma-Ata. The second identifies the principal parameters of global change in the coming decade, and illustrates their effects on health and health care. The third section summarizes discussion on six current issues which will remain critical in enhancing or retarding PHC implementation in the coming decade. The fourth section maps out three major areas of need for better monitoring of PHC, and the fifth draws together conclusions for the discussions of the Committee. Recommendations for action by WHO are contained in the sixth, and final, section.

CONTENTS

1. BACKGROUND AND CONTEXT

The Alma-Ata Conference in 1978 endorsed the goal of Health for All by the Year 2000, and declared primary health care to be the mechanism for achieving this goal. The ensuing decade has seen both solid progress and serious setbacks. Some countries maintain a priority commitment to PHC and can demonstrate successful progress in improving the accessibility and quality of health care. In others, falling living standards, massive indebtedness and ecological decline have had a devastating impact on health services and health status.

PHC can work!

The Committee felt it important to stress that there are examples, on both small and large scale, where the concepts of PHC have been applied and have had proven impact. What are the ingredients of success?

- persisting national political, social and financial commitment, with clear policy and administrative guidelines that reach to the periphery;

- strong management capabilities that can implement the programmes, including management information systems that track equity and effectiveness and point toward those who are especially at risk;

- health personnel oriented and trained so as to understand and have their own commitment to the implementation of PHC;

- decentralization to district and sub-district levels so that management decisions can be made with close relevance to local conditions;

- community participation with active involvement in local decisions about PHC planning and implementation;

- sustained financing, preferably with community in-put to the extent that it will engender a sense of ownership but without inhibition of usage;

- PHC programmes that bring life-saving technologies to individual families at costs that are affordable even in the midst of poverty.

In contrast, the ingredients of failure are:

- lack of national policy and social commitment;

- financing of health services that is not linked to and supportive of equity and cost-effectiveness objectives;

- health personnel without the training and orientation required to either understand or implement PHC;

- communities uninvolved in either the planning or implementation of PHC programmes;
- management systems that are inadequate to guide services toward either universal coverage or even those most in need;
- district health services that do not serve as a distinctive framework for the management of health services, including the integration of PHC with related referral care.

Why this mixed picture? Among many possible explanations, two stand out:

- while PHC may be simple to describe and advocate, it has proven to be much more complex to implement, particularly as its social, economic, managerial and epidemiological interactions become more apparent, and there remains a confusing array of perspectives about what PHC is, and how to do it;
- even where PHC appears to be well understood, there are many countries where the conditions of underdevelopment are severely obstructive, and health services agencies are resistant to change, or cannot find their ways to constructive change.

For the decade ahead, there is a further factor to be taken into account. The context in which PHC will be pursued, whether global or local, is changing, often dramatically. Social, political and economic shifts are occurring with surprising speed and scale. There is no doubting that such changes will continue but their precise direction is impossible to predict. The implications for PHC point to the need for flexibility, pluralism and responsiveness.

Thus, the dominating challenges of today are:

- to adapt and clarify the meaning, content and potential of PHC; to develop a common sense of that potential and a global commitment to its purpose;
- to document and analyse the reasons for widespread failures in the implementation of PHC; and to develop clear and practical guidelines towards successful implementation.

Dr Nakajima, the Director-General of WHO, established the Consultative Committee on PHC Development to address these questions.

The Director-General asked for a fresh assessment of PHC. His question was <u>not</u> to ask if PHC was the correct priority for WHO - that was fully established in WHO and supported by the Director-General. Rather, the question was: What is needed to ensure timely and effective implementation of PHC as the means for progressing towards health for all?

This Report lays out the Committee's responses.

The Committee endorsed the viability of the PHC strategy, both for advances in health and to development more generally. For countries to abandon PHC, or to allow themselves to fail in its implementation, is to turn away from the approach to health care that has by far the strongest rationale in terms of political, economic and social reality.

The Committee noted many examples of effective PHC programmes. But implementing them requires dedication at all levels of the health system, and determined application of known principles and steps. It stressed that making PHC operational cannot be achieved through a few changes in the margin - it requires radical, system-wide change.

The Committee also felt that, when they asked "What has worked and what has not?", it was clear that there is no appropriate information base to support those observations.

The lack of an informative data base that documents experiences, and allows analysis of both successes and failures, in implementing PHC highlights a critical trouble spot for WHO as it formulates its approach to supporting Member States in their quest for health for all through PHC.

For WHO to be effective in supporting PHC development in these countries, careful consideration of the information base that is required to inform and sustain this work is necessary.

2. THE CHANGING GLOBAL CONTEXT OF THE 1990s

The world is changing - its people and their circumstances, its political systems and power blocs, and the physical environment. A number of these changes have direct linkages to health; others have indirect but still powerful potential effects on both health and health care. The economic decline of countries in greatest need continues as the prospects for prosperity in the industrialized world improve. Population growth and demographic change, including rapidly increasing urbanization, pose direct threats to health when, as a result of poverty, they are rapid and uncontrolled. Environmental degradation - consequence of affluence in some areas and of poverty in others - is already reaching levels which damage the health of large populations. The global political map is undergoing rapid transformation, with integration and disintegration often proceeding simultaneously in the same region. Peoples' health and welfare is in a period of unprecedented fluidity. In addition, many countries are actively restructuring or reviewing their health systems, and are looking forward for experiences to adapt or to avoid.

The prospects for the more widespread implementation of PHC cannot be separated from this global scenario. PHC strategies will thus need to be adaptive to the changing circumstances of communities and countries.

The following sub-sections summarize selected needs, which can be identified with some confidence, which will define the local context of PHC.

Population growth rates will be substantially lower in the 1990s than during the 1960s and 1970s, but these declines will come too late to avert the population explosion of the next decade - the world's population will grow from 5.3 billion in 1990 to 6.3 billion by the year 2000. This addition of 1 billion people to the world's population amounts to a 20% increase, and means an increased demand for health services of about the same order. The increase will be proportionately greater for developing countries, whose population increase will be 22%. In some countries, where growth rates are close to 3%, the increase of population and demand for services will be of the order of 35%.

Health budgets for those countries will not increase proportionately, and even existing health budgets do not provide total coverage with PHC services. Thus dramatically altered strategies for financing and organizing health care are essential.

Such huge increases in populations also have serious implications for the food and water supply. Water is already running short in many countries and famines are recurrent. In the absence of land reform, the rush to the cities will continue, and the urban slums, with their associated health, social and environmental problems, will become politically unmanageable in many countries.

The impact of the surging population on health, environment, food, water supply and other facets of development are no longer distant possibilities - they are immediately at hand, in the 1990s.

Two demographic pressures likely to have the greatest implications for PHC in the 1990s are population aging and urbanization.

The proportion of the world's population aged 60 and over continues to rise. By the year 2000, the figures for the developed countries will be 18.7%, and for the developing countries, 7.6%. The absolute numbers of the elderly are much greater in developing countries - by the end of the century the size of the elderly population in developing countries will be greater than in developed regions, by the ratio of 380 to 236 million.

It is unlikely that there will be any slowing of the flow of young adults moving to the cities, leaving behind the elderly population, often severing the traditional social support structures for the aged. But the natural rate of population growth in many cities now exceeds growth from migration. The proportion of developing country populations living in urban areas will rise to nearly 40% by the end of the decade, compared with 75% for developed countries. By that time, 18 cities in the Third World will have populations of greater than 10 million, most of whom will be living in poverty.

Taking together the demographic, economic, environmental and political problems of the large Third World cities, it is imperative to rethink the whole question of PHC services to the urban poor, not in sectoral isolation, but, where possible, as part of coherent approaches to urban development.

There has been a striking worldwide increase in awareness of the threats posed to health from environmental risk factors.

Poverty has become an increasingly environmental phenomenon - the poor both suffer from and contribute to ecological decline. Economic deprivation and environmental degradation reinforce one another to form a downward spiral.

Poverty increasingly claims women and children as its victims. The feminization of poverty follows from the fact that the poor are more likely to be female than male. Women are educated less than men and are therefore less competitive for work, and they are paid less for the same jobs. Children are the most constant victims of poverty - two-thirds of the absolute poor are children under the age of 15.

Poverty fosters ecological deterioration as desperate people exploit their own resource base, sacrificing their future to salvage the present. A striking difference is seen between poor but secure small land holders versus dispossessed and insecure landless.

As the poverty trap tightens, the poor become more insecure and dispossessed, and the conditions for ecological degradation spread across fragile lands. It is not surprising that childhood malnutrition and ecological deterioration are closely coupled, and that global maps of the deepest poverty and the worst ecological deterioration are almost identical.

Any constructive approach to this problem of poverty and ecological deterioration must include the poor as essential participants.

Massive and potentially irreversible environmental destruction is a serious threat globally, and calls for vigorous international action to arrest such trends. Immediate targets for policy and action are deforestation, acid rain, rising atmospheric concentration of carbon dioxide and management of hazardous wastes.

A crucial trend is that the gap in the environmental sector will narrow between the developed and developing countries, and there will be increasing emphasis on global solutions based on interdependencies among countries.

Water and waste

While it can be hoped that there will be improvements in water and waste control in the 1990s, the major issue will not be access to but availability of safe water.

Per capita global water supply will decline, with household and industrial sectors competing with the agricultural sector for the limited quantities of water. At the same time, the degradation of water resources from such factors as mismanaged irrigation, and discharge of industrial wastes and untreated sewage in surface water, will jeopardize available sources.

Differential economic growth will continue to characterize the 1990s. The 1980s saw a serious deterioration in the world economy. Prior to 1984, the net flow of resources was from North to South, but by 1988 there was a reverse flow of $ 50 billion per year. Capital flight from Third World countries equalled the total debt.

Economic growth of the industrialized countries is expected to continue at 3% per annum, and reductions in defence expenditure and the development of new markets in Eastern Europe could raise growth to even higher levels.

Growth prospects for the developing countries vary from optimistic to disastrous, being fastest in the rapidly industrializing countries of Eastern Asia. Conversely, severe economic decay is expected to continue in sub-Saharan Africa, parts of Latin America and the Caribbean, and low-income Asia.

Unless forceful and effective means are found to reverse the negative flow of resources, now mainly from South to North, to take positive and meaningful steps toward economic recovery, the development prospects for the poorest countries are very grim. The 1980s has been called the "lost decade" because of the severe economic deterioration. What will the decade of the 1990s be called?

Structural adjustment policies in many developing countries will continue to force tight governmental control over expenditures on health and social services, often to the detriment of poorer populations.

The economic argument for PHC must be made repeatedly and forcefully, using cost-effectiveness and equity as the bases for advocacy.

The 1990s should see more varied approaches to health services financing. Recent attempts by governments to shift payment burdens on to consumers have often been inequitable and inefficient. There is a place for communities to share in the costs of services, but the approach should be through community participation, and not simply imposed from above.

Democratization. The current tendency towards more democratic forms of government should lead to an increasing demand by the people for more equitably distributed and more effective services, including a meaningful voice in decisions on priorities and modes of provision of health services. The unfolding experiences in

Eastern Europe will yield particularly important lessons for PHC, since radical changes are under way in both political and economic spheres, which will inevitably impact heavily on health and the health sector.

Education. Education has an immense potential for positive linkages to the health of populations, particularly of girls and women. But two further problems need to be addressed. One is the limited access many people in the poorer countries have to education. There the need is for informal education, literacy and other approaches to learning in the midst of deprivation. A second issue has to do with the cultural autonomy required to make full use of education, as is the need of women in societies where culture limits their roles in family and community affairs. In such situations, it is necessary to enhance their roles in development while still remaining consistent with cultural values.

Health status

Trends in health status in both developed and developing countries that will reach into the 1990s are already apparent. Infectious and parasitic diseases will continue to dominate the epidemiological profile of poor countries into the 1990s, for as long as cheap and effective solutions remain unused, or in some cases unavailable. In addition, the full impact of AIDS in reducing the economically active population will become clearer during the 1990s.

In developing countries, there will be a gradual and continuing addition to the diseases of infection and nutrient deficiency, as the diseases of the more advanced societies become more prevalent:

- diseases of the circulatory system now probably account for almost as many adult deaths (approximately 6 million) in developing countries as all infectious and parasitic diseases combined;

- in the late 1980s, cancer alone is thought to have accounted for about 2.5 million adult deaths per year, similar to the total for tuberculosis and 10 times the mortality among adults from malaria;

- chronic lung disease, closely linked to cigarette smoking and air pollution, will claim over 2 million lives in 1990, or as many as are lost to all external causes of death;

- as uses of tobacco, alcohol and drugs by women continue to spread in both developed and developing countries, rates of low birth weight will increase;

- male life expectancy, which has been declining in parts of Eastern Europe, may, with changes in the economy and life styles, shift to follow the pattern of Western Europe and North America;

- there will be increasingly apparent effects of environmental conditions, including: foodborne diseases; environmentally caused neoplasms of skin, stomach and lung; and environmentally related accidents.

3. IMPLEMENTING PHC IN THE 1990s

Equity, which incorporates the ideas of universal coverage and care according to need, was seen by the Committee as the main defining value of the PHC strategy. Closely linked to equity are the needs for efficiency and effectiveness.

These three parameters - equity, efficiency and effectiveness - are all essential in PHC.

Substantial differences still exist in how PHC is understood, even among those who work with PHC on a daily basis in different parts of the world. Some consider PHC the level at which care is given - community, health centre, private office, hospital. Others think of PHC in terms of programmes, such as immunizations, oral rehydration therapy, etc. For still others, it is a strategy, which includes levels and programmes, but it is more than these - it is also a direction, a philosophy.

This lack of a coherent view of the meaning and purpose of PHC, coupled with the lack of a dependable information base, together form a very large challenge for WHO.

To deal with this double deficiency, there must be effective efforts:

- to clarify the full meaning, content and potential of PHC, and to try to develop a common global perception of that meaning and commitment to its purpose;

- to develop an information base that documents examples of and reasons for various degrees of success and failure in the implementation of PHC:

The Committee identified six decisive issues in PHC implementation.

1. Community participation

Community participation is a programmatic necessity. Without close involvement of the community, and its families and individuals, in health promotion,

disease prevention and care of the sick, there is little likelihood that health services will have a durable impact on the health of the community.

A paradoxical aspect of community participation is its variability in different settings. While PHC may be envisioned as following a set strategy, particularly as seen from the policy-maker's or planner's point of view, the principles of adaptation to local circumstances, and of community self-determination, result in countless variations. While this may result in problems of generalization and management, it is also part of the essential pluralism of PHC:

> **... Increasingly it is appreciated that adaptation to local circumstances, even in ways that are entirely unique, is the essence of effective PHC, and essential to its universal applicability.**

2. District health systems

A critical issue in PHC development since Alma-Ata has been to progress beyond policy statements to programmatic implementation. Many things can go wrong in moving from central policy-making to field-based implementation. The district is the key location in most health systems to test and consolidate the PHC strategy.

The district represents an organizational entity which in size, budget and function can be structured for replicability in other settings, and even multiplied into large-scale health care systems.

The necessary ingredients for health development are there: communities in need; the challenges of dispersed rural or crowded urban populations; a network of primary and secondary health facilities; a hierarchy of workers; potential linkages with other sectors; and social, governmental and political organizations.

The district can play a pivotal role in matching local needs and priorities with national policy guidelines and resource allocations. Playing this role effectively requires decentralization to the district of both responsibility and resources. The district also has the potential to improve the integration of various programmes within the health services, and to resolve the knotty problem of selective programmes versus integrated PHC. The district can also promote more coordinated efforts of various governmental, private, voluntary and community groups.

One of the most difficult linkages to establish among the various levels of health services is between hospitals and peripheral health units, and it is especially difficult where it is most important - between the front-line or district hospital and the community. This linkage is a key piece that is often missing in the development of health services, and the district system is the proper place to pursue it. These points are taken up again in the section on "system balance" below.

3. Financing health services

Attention to the financing of health services has an importance that goes beyond the search for additional resources.

A careful approach to financing is the route to ensuring equity, efficiency and quality of care. The case can be made to policy-makers that PHC is a policy instrument especially suitable for tightly constrained economies. In plain fact, PHC is the only route to equity in the face of scarcity.

Recognition of the limitations of government in financing universal health care was probably the major lesson of the 1980s. In turn, this has led to over-optimism about the capacity of people to pay for health care in some poor countries, where evidence indicates that people already pay a higher proportion of their health care costs than in most industrialized countries, and recent drops in utilization levels have been observed.

During the 1990s, the importance of government as a regulator and standard setter in health care is likely to emerge, as well as a more realistic understanding of the potential financial contributions of nongovernment sources of financing.

Several distinctions need to be made: between sources of financing, payment mechanisms, and providers of care, and between three types of financing strategy:

(1) mobilizing additional resources from outside the health sectors;
(2) mobilizing additional resources from within the health sector (e.g., through user-charges); and
(3) improving the use of existing resources.

The goal of equity, which is central to the Health for All approach, and the need to demonstrate economic efficiency, can be attained simultaneously through a fuller commitment to PHC. Since the greatest health needs are among the poor, the maximum improvement in the health status of populations is possible when the most cost-effective actions of primary health care are targeted to the groups most at risk.

An optimal allocation of health resources thus involves, for most countries, a larger share of expenditure for community-based primary health care. Social justice and sound economics are thus combined in support of PHC.

4. Management of PHC

The characteristics of PHC - equity, efficiency, effectiveness, community participation - provide the possibility of major impacts on the health and well-being of populations - but not automatically so. Careful management is critical to achieving the promise of PHC.

The heart of the managerial processes are: capacities to assess needs; select priorities; establish and maintain a PHC infrastructure that will reach into communities and households; organize PHC programmes responsive to needs, including referral and back-up; train appropriate personnel; maintain supplies and communications; track costs and expenditures and oversee, monitor and evaluate the PHC system.

A critical ingredient is the information system that provides a framework for field level observations; aggregating such reports into an overview of health care and health status changes, feeding back reports to field staff and feeding forward to those overseeing the programmes.

Management is a tool of policy and purpose. To be effective, the system it is managing must have the right direction and philosophy. PHC committed to equity and community participation can be advanced through strong management to the benefit of the health and development of the people.

5. System balance

A health care system must find a balance between primary, secondary and tertiary health care. Doing so requires another kind of balance - between social, political, professional and economic pressures.

A country that cannot establish a solid basis for PHC, is turning away from the most economical approach to the needs of its most vulnerable and needy populations.

To fail to develop secondary care support systems for PHC, risks both failure to provide life-saving specialized care, and also the loss of credibility of the PHC system itself.

To concentrate mainly on tertiary care is to give over priority to technology and to health professionals who champion it, which may have some importance to the long-term development of the health sector, but at a cost of inadequate contemporary care for the majority.

Finding the balance requires a clear understanding of the appropriate interactions of the three levels, promotion of public and professional awareness of the need for such balance, firm policy-making, and policy-related budgeting.

6. Sustainability

Without sustainability, PHC becomes a wasted investment and a lost cause.

PHC involves complex interactions among social, technical, financial and political factors, often complicated by conditions of donors or other partners, making

programmes vulnerable and nonsustainable, particularly when directed mainly by short-term goals.

Countries need to learn how to assess and monitor sustainability factors in order to take corrective action when required. As the monitoring of PHC implementation has improved, there has been an accumulation of empirical evidence pointing to a range of important "sustainability factors". To illustrate:

- national commitment. In too many countries the commitment to PHC has been vague and ambivalent. There have not been clear signals to the public and to the health services of the importance given to PHC. Explicit statements of purpose and detailed implementation strategies are needed at all levels to ensure sustainability;

- donor support. If development is the principal objective of donor support, then sustainability must be the ultimate indicator of success. The donor coin has two sides. There has been a disappointing array of failures due to a range of reasons, from poor planning to incompetent management. But the donors are often part of the problem due to uncoordinated investments, short time frames for support, narrowly focused programmes, external priority setting;

- ability of the health sector to learn. Where implementation has not gone well, it is essential for those involved to profit from the failures and build those lessons into the next round of PHC development.

An undoubtedly key factor in sustainability is how communities perceive their own needs, and to establish priorities and programmes on that basis. A strong and enduring health infrastructure can both involve communities in its establishment and be flexibly responsive to community needs and interests.

4. MONITORING PROGRESS IN PHC

For WHO to provide effective leadership and support in this complex and evolving field requires the development and maintenance of an information base that can guide both WHO and the Member countries in PHC development.

Monitoring is required in three broad areas.

First, is the need to seek out and report on examples of PHC strategy and design. Which countries, nongovernmental organizations, communities have undertaken substantial PHC initiatives, and what has been their experience? The field of PHC development has extended far beyond the stage at which there are a few focal points. There has been a striking diffusion of creativity, and it is imperative that there be a monitoring of its progress.

Research will make crucial contributions to progress in this field. In particular, health systems research, including epidemiological, economic, managerial and social approaches, will provide important insights into fruitful avenues of PHC development.

Second, and closely related to the first, is the need for methodologies that can be used for measuring and monitoring the PHC systems. This will require the application or development of indicators that can be used for monitoring the critical phases of health systems development, including impact on health status and related social and economic factors. Measures of equity, efficacy, efficiency and community participation are critical parameters.

There are at least two levels for such monitoring:

- one would be intrinsic to PHC systems, locally or nationally, where there should be management information systems that track key parameters, such as coverage, equity, costs and effectiveness;

- the other would be regional or global mechanisms for following the stability and effectiveness of such systems. For these purposes, WHO could combine two approaches. One would depend on aggregating data from local or national information systems. The other would be to use some kind of a network of reporting sites, possibly the PHC equivalent of sentinel epidemiological sites.

Such measuring and monitoring is imperative if WHO is to reduce the uncertainty that is pervasive about progress, or the lack of it, with respect to PHC. Progress can be documented, and also the reasons for it. Comparative strengths and weaknesses of different approaches can be laid out for countries to see. In this way, WHO and its partners in PHC development need not be blind to field-based experience of others.

Finally, WHO should follow trends - social, political, economic, environmental - in the global or local context within which PHC is to be implemented. WHO will need to establish collaborative relationships with other organizations that can assist in monitoring the non-health sectors, as well as in analysing the implications of those trends for health. Arrangements for tracking PHC systems and their effects, as through field-based sentinel sites, could add considerably to the analysis of the impacts of contextual trends on health.

5. CONCLUSIONS

Looking back to Alma-Ata, and asking what are the lessons of the past decade, the most important message is not to be gained from asking: Did Alma-Ata make a difference? Of course Alma-Ata made a difference!! Alma-Ata led us to the global vision that HFA through PHC is an essential and indispensable goal for all countries, rich and poor! The question has been overtaken by others.

To say that progress with PHC has been disappointing, and leave it at that would be to miss the critical point. PHC remains the indispensable goal of health development, but bringing it to operational reality has turned out to be much more complex, difficult and exacting than had been foreseen.

- Conceptually, there has not been clarity about either its content or purpose. The need is to hammer out an unclouded understanding of PHC as a strategy and philosophy, and forge that into a widespread and commonly held perspective as the basis for a renewed global commitment to health development through PHC.

- Strategically, there has been doubt as to which approaches to PHC have worked and which have not, but the information base on which such doubt rests is itself incomplete. PHC has worked ... in many places, with different approaches, and the reasons for some strategies working and others not are known. But that knowledge is not systematically ordered and available, and it should be. Meanwhile, new and creative initiatives in PHC are under way, the results of which need to be captured, assessed and disseminated.

- Programmatically, there has been uncertainty and disagreement as to the critical ingredients of PHC - technical, social, economic, and across sectors - and how they should be organized and managed. This is an evolving field, in which trials, analysis and research must be a part of every day work, the findings shared and disseminated, and that process encouraged and supported.

- Socially, there has been an under-appreciation of the importance of community participation and local determination of priorities and programmes. The immense diversity in the nature of the problems that bear on health, and the ways in which solutions must vary, from community to community and across the full range of developed and developing countries, makes decentralization and local determination indispensable. Here, too, new initiatives are under trial, calling for fresh approaches to review and analysis.

Finally, the rapid and profound shifts that are occurring in the global, social, political, economic and ecological environment requires that PHC development be seen as inextricably tied to the larger development matrix. The challenge of PHC finding its place in that context calls for continuous and interdisciplinary scrutiny and exploration.

The Committee is convinced that WHO can and should respond to these challenges and uncertainties. To do so, however, the Organization must take assertive steps to move to new levels of analysis, advocacy and action, as specified in the accompanying recommendations.

6. RECOMMENDATIONS: ACTION BY WHO FOR THE 1990s

Drawing on their wide-ranging discussions, participants put forward the following recommendations to the Director-General for action by the World Health Organization. In so doing there was unanimous agreement on the need to re-emphasize the principle of equity as the key to achieving Health for All and, consequently, as the overriding factor in PHC implementation as well as the yardstick against which to measure its impact.

1. RENEWED ADVOCACY OF THE PHC APPROACH

1.1 WHO should initiate a campaign to renew the Organization's advocacy of the PHC approach. Such a campaign should emphasize the need for action to make the principles of PHC operational and the implications for change at all levels in countries. In doing this WHO would ensure that the lessons from the decade of experience are clearly summarized and given prominence in proposals for future action.

1.2 WHO should periodically clarify the rationale for the primary health care approach and its application in the changing context of the 1990s as a means of sustaining global confidence and commitment to its implementation.

1.3 Special efforts are required to make health development an important issue beyond the health sector. To this end, WHO should develop a strategy for promoting the PHC approach amongst leading figures in countries and the international community, enlisting their active participation in an advocacy campaign (see 1.1 above).

2. WHO SUPPORT FOR PHC IMPLEMENTATION

2.1 Development of national policies and strategies

As a matter of urgency, WHO should support countries to renew and strengthen their health development policies and strategies in order to ensure appropriate adaptation of the PHC approach. In this regard, the Organization

should undertake the following actions:

(a) promote and support country reviews of policies and strategies of PHC implementation. In this connection, WHO should promote strategies to strengthen health systems development and strong management, with emphasis on the district level. Emphasis should be placed on the integration of separate health programmes, as a means of responding to specific local needs and coping with change, as well as increasing and strengthening community involvement in health development, including strategies for changing the attitudes of health personnel and improving their support;

(b) promote and support production of well-written national strategy documents to be used in orienting personnel and leaders to PHC in specific country settings and as guidance for PHC implementation at all levels. This will include specification of changes to be implemented at all levels in order to improve sustained implementation in districts;

2.2 Strengthening organization and management of national health systems

The need to strengthen organization and management of health systems in support of the PHC approach has been recognized since the time of Alma-Ata. Countries are looking to WHO for support in this matter which is now of greater importance than ever before. To this end it is recommended that WHO should:

(a) support appraisal of health systems organization and management, their ability to support PHC implementation, their efficiency, financing, costs and effectiveness, in order to identify feasible options for improvement. This should include all contributors and potential contributors to health development - government, NGO, private and traditional. Such appraisals could be national reviews based on, for example, WHO's Joint PHC Review methodology or more circumscribed reviews conducted over a short period of time;

(b) support management development at all levels through identification of the new roles and responsibilities to be adopted, analysis of organizational changes required for sustained and effective implementation of PHC and the development of appropriate management training. A further important component should be the development of an information system to support improved decision-making, particularly at district level;

(c) support analysis of financing options appropriate to specific country circumstances and the strengthening of financial management, particularly at district level, as means of promoting equity and efficiency;

(d) support the development of capabilities to analyse the contributions, both positive and negative, of other sectors to health development and to influence sectoral policies in favour of health development;

(e) support HSR and the adoption of problem-solving approaches as an integral part of strengthening health systems at all levels. To this end, networks of institutions, agencies and districts should be established to support the strengthening of technical capabilities and the exchange of expertise and experience.

3. STRENGTHENING WHO'S CAPACITY TO PROVIDE SUPPORT

In the light of the importance which the Director-General attaches to PHC implementation, it is recommended that WHO should strengthen its capacity to provide support to countries. In this regard WHO should:

(a) review the roles and responsibilities of all programmes and all levels of the Organization in order to improve their ability to provide appropriate support to PHC implementation, including key strategies such as decentralization, community involvement and integration of programmes;

(b) strengthen the Organization's ability to communicate technical information on PHC implementation, with emphasis of developing the means to reach mid-level health workers who are the key to effective PHC.

4. MEASURING AND MONITORING PHC DEVELOPMENT

4.1 WHO should establish mechanisms for systematically monitoring and following up initiatives which it regards as important in advancing understanding of PHC implementation.

4.2 WHO should develop, test and evaluate a range of possible methodologies for measuring and monitoring PHC implementation. This work should include the development of indicators to monitor health systems development, health status, social and economic factors and the relationships between them.

4.3 WHO should monitor and analyse trends in selected areas which have important implications for PHC implementation. These will include the following:

- population growth and related changes in demographic, urbanization and disease patterns;
- socioeconomic trends and their impact, especially on the poorest countries and communities;
- environmental degradation and its impact on health;
- the role of women in health and social development;
- promising developments in health systems and biomedical technologies.

In view of the variations which occur between and within countries with respect to the above, it will be extremely important to ensure the avoidance of crude global aggregations of data which, although undoubtedly interesting, are not likely to be useful for guiding effective action.

In conclusion, participants suggested that the Report of the Meeting should be used by WHO to develop an Agenda of Issues for future, more specific discussions with the aim of providing timely technical support to the Organization's programme of action for PHC.

ANNEX

CONSULTATIVE COMMITTEE ON PHC DEVELOPMENT

Geneva, 9-12 APRIL 1990

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